HOMETOWN PHARMACY

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(Pharmacy Use Only)

# Vaccine Administration Record (VAR)

## SECTION 1: Patient Information

**Name**: _____ **Date of Birth**: _____ **Gender**: ☐ Female ☐ Male

**Address**: _____ **City**: _____ **State**: _____ **Zip Code**: _____

**Phone Number**: _____ **SSN**: _____ **Ethnicity**: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

**Race**: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Pacific Islander or Native Hawaiian ☐ Other

## SECTION 2: Immunization Selection

Which vaccine(s) are to be administered?: ☐ Flu ☐ RSV ☐ Shingles ☐ Tetanus, Diphtheria, Pertussis (Tdap) ☐ COVID ☐ Pneumonia ☐ Hepatitis ☐ Other: _____

***Pharmacy Use Only***
Confirmed with patient prior to administration:
_____
Immunizer Initials

## SECTION 3: Immunization Questionnaire (Questions pertain to person to be vaccinated)

| | |
|---|---|
| 1. Within the last 14 days, have you felt ill with fever, cough, or shortness of breath; or tested positive for COVID-19, had exposure to someone who tested positive for COVID-19 or are you currently sick? | ☐ Yes ☐ No ☐ Unsure |
| 2. Do you have allergies to medications, food, latex, a vaccine ingredient? (*examples*: polyethylene glycol, polysorbate, eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, or yeast) | ☐ Yes ☐ No ☐ Unsure |
| 3. Have you ever had a serious reaction after receiving any vaccination? (*examples*: anaphylaxis, MIS, myocarditis) | ☐ Yes ☐ No ☐ Unsure |
| 4. Do you have any long-term health problems? (Check all that apply) ☐ Diabetes ☐ Lung Disease ☐ Heart Disease ☐ Kidney Disease ☐ Blood Disorder ☐ Asthma ☐ Asplenia ☐ Cochlear Implant ☐ Cerebrospinal Fluid Leak ☐ Other | ☐ Yes ☐ No ☐ Unsure |
| 5. Do you have cancer, leukemia, HIV/AIDS, asplenia, or another condition that may weaken the immune system? | ☐ Yes ☐ No ☐ Unsure |
| 6. Have you ever had a seizure, brain or nervous system disorder, or Guillain-Barre' Syndrome? | ☐ Yes ☐ No ☐ Unsure |
| 7. **For women**: Are you pregnant, breastfeeding, or could be pregnant in the next month? | ☐ Yes ☐ No ☐ Unsure |
| 8. Have you received any vaccinations or skin tests (i.e. TB test) in the past 4 weeks? | ☐ Yes ☐ No ☐ Unsure |

## SECTION 4: Consent for Vaccination

I certify that I am: (i) the patient & at least 18 years of age; (ii) the parent or legal guardian of the minor Patient: or (iii) the legal guardian of the Patient. Further I hereby give my consent to the healthcare provider of HomeTown Pharmacy to administer the vaccine(s) I have requested. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccines. I understand the risks and benefits associated with the requested vaccines & have received and understand the Vaccine Information Sheet for these vaccines. I also acknowledge that I have had chance to ask questions & that questions were answered to my satisfaction. Further I acknowledge that I have been advised to remain near the vaccination area for 15 minutes for observation by the administering health care provider. On behalf of myself, my heirs, and personal representatives, I hereby release & hold harmless HomeTown Pharmacy, its staff, agents & employees from any all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of these vaccines. I authorize HomeTown Pharmacy to release any medical or other information to my health care professionals, Medicare, Medicaid, or other third-party payor necessary to effectuate care or payment & request that payment of authorized benefits be made to HomeTown Pharmacy with respect to the vaccine(s) received. If it is determined that this vaccine is not a covered benefit, HomeTown Pharmacy may bill me directly for the vaccine & administration.

**Signature: _____** **Date:_____**

**Parent/Guardian Name (PRINT): _____** **Relationship to Patient:** ☐ Mother ☐ Father ☐ Parent ☐ Guardian ☐ Self

## FOR PHARMACY USE ONLY

| Vaccine | Manufacturer | Lot # / Expiration | Date on VIS | Site |
|---|---|---|---|---|
| 1. | | | | ☐ Left ☐ Arm ☐ IM ☐ Right ☐ Leg ☐ SQ |
| 2. | | | | ☐ Left ☐ Arm ☐ IM ☐ Right ☐ Leg ☐ SQ |
| 3. | | | | ☐ Left ☐ Arm ☐ IM ☐ Right ☐ Leg ☐ SQ |

**Immunizer Signature: _____** **Date Immunization & VIS Provided: _____**